AMENDED IN ASSEMBLY MARCH 2, 1998

CALIFORNIA LEGISLATURE—1997–98 REGULAR SESSION

ASSEMBLY BILL No. 1717

Introduced by Assembly Members Richter, Baugh, and Granlund

January 29, 1998

An act to add Section 1368.07 to the Health and Safety Code, relating to health coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1717, as amended, Richter. Health coverage.

Existing law provides for the licensure and regulation of health care service plans by the Department of Corporations.

Existing law requires a health care service plan to disclose to the commissioner and to providers under contract with the plan, and, upon their request, to enrollees or persons designated by enrollees, the processes the plan uses to authorize or deny health care services by a provider pursuant to the benefits provided by the plan. Existing law requires a plan rejecting a claim to disclose the specific rationale for rejecting the claim to the provider or the enrollee, or both, upon request.

This bill would require a health care service plan that uses a utilization review system for a case-by-case assessment of frequency, duration, level, and appropriateness of medical care and services to determine whether medical treatment is or was reasonably required to make available to the Commissioner of Corporations a written summary of the

system. It would require the utilization review system to comply with various requirements, including requirements for authorization of treatment and for the availability of an external independent review procedure as a precondition to the denial of treatment or payment of the provider.

Since a willful violation of these requirements by a health care service plan would be subject to criminal sanctions punishable by fine or imprisonment, or both, this bill would impose a state-mandated local program by imposing a new crime.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1368.07 is added to the Health and Safety Code, to read:

1368.07. (a) As used in this section:

(1) ''Request for authorization'' means any written request for assurance that appropriate reimbursement will be made for a specific course of proposed medical treatment.

(2) ''Notice of treatment authorization denial'' is a written denial of a request for authorization.

(3) ''Notice of request for additional medical information'' is a written response to a physician's request for authorization requesting further information. If the physician does not respond to the request for additional medical information, it will be presumed the request for authorization is withdrawn.

(4) ''Notice of treatment authorization'' is a written response to a physician's request for authorization authorizing treatment.

(5) ‘‘Utilization review’’ is a system used to manage costs and improve patient care and decisionmaking through case-by-case assessments of the frequency, duration, level, and appropriateness of medical care and services to determine whether medical treatment is or was reasonably required. Utilization review includes, but is not limited to, the review of requests for authorization, and the review of bills for medical services for the purpose of determining whether medical services provided were reasonably necessary. Utilization review does not include bill review for the purpose of determining whether the medical services rendered were accurately billed.

(6) ‘‘Written’’ includes an electronic facsimile or electronic mail, as well as communications in paper form.

(7) ‘‘Medically based criteria’’ are standards used for evaluating whether medical treatment is reasonably required. Medically based criteria shall comply with all of the following:

(A) Be based on professionally recognized standards.

(B) Be developed using sound clinical principles and processes.

(C) Be developed by physicians, with the involvement of actively practicing health care providers, and be peer reviewed.

(D) Be evaluated at least annually and updated if necessary.

(E) Be signed and dated by the physicians responsible for development.

(b) Every health care service plan shall maintain and make available to the commissioner upon request, a written summary of the plan’s utilization review system, including all of the following:

(1) A description of the process whereby requests for authorization are reviewed and decisions on those requests are made, including a concise description of how the requirements in subdivision (c) are met by the process.

(2) A description of the specific criteria utilized in the review and throughout the decisionmaking process,

including treatment protocols or standards used in the process. It shall include a description of the personnel and other sources used in the development and review of the criteria, and methods for updating the criteria.

(3) A description of the qualifications of the personnel involved in implementing the utilization review system and the manner in which these personnel are involved in the review process.

(c) Any utilization review system shall comply with the following minimum standards:

(1) Upon receipt of a written request for authorization, a plan that does not wish to authorize the proposed treatment shall issue a written denial, or request for additional medical information to the health care provider, which shall be transmitted or placed in the mail in a reasonable time, but no later than seven working days after the plan's receipt of the request and any necessary supporting documentation. When medically necessary, the plan shall make an expedited review of the request for authorization. No delay shall exceed 14 days from receipt of the written request for authorization.

If the physician expressly requests the plan to make its authorization in writing, the plan shall do so.

(2) A plan may initially use a nonphysician reviewer to apply medically based criteria to the evaluation of a request for authorization or a bill for medical services. However, no request for authorization may be denied, and no requests for payment shall be denied or reduced on the basis that the services provided were not reasonably necessary unless the person making the request has been given an opportunity to have the request reviewed by an external independent review procedure.

(3) Only medically based criteria shall be used in the utilization review and decisionmaking process. The actual text of the criteria applied in a particular case shall be made available to the affected health care provider and patient upon his or her request. If requested, the actual text shall be provided by electronic facsimile.

(4) A plan's failure to make a timely response to a request for authorization as required in this section shall constitute an authorization to the provider to proceed with the treatment plan and a promise to reimburse the provider. It shall also constitute a ''prior authorization'' for particular treatments. However, a plan that fails to make a timely response may nonetheless contest the necessity of medical treatment that has been rendered if the plan shows by clear and convincing evidence (A) that its failure to make a timely response was for good cause ~~or through excusable neglect~~, and (B) that the medical treatment that was rendered was plainly unnecessary.

(d) A plan that authorizes a specific type of treatment by a provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization.

(e) A primary treating physician may, within 10 days of the issuance date of a request for additional medical information, provide the requested information, or make a written statement to the plan explaining the physician's disagreement with the plan's medical criteria.

(1) If a plan has received no response to a notice of request for additional medical information within 10 days of issuing the notice, it is presumed that the primary treating physician has withdrawn the request for authorization.

(2) If a plan has received any written response from the physician within 10 days of issuing the notice of request for additional information, the plan shall, within 10 days from receipt of the physician's response, do either of the following:

(A) Deny the authorization.

(B) Provide the physician with written authorization to proceed with the treatment plan.

(3) A plan's failure to deny an authorization following a physician's response to a notice of request for additional medical information shall constitute an authorization to the physician to proceed with the treatment plan and a promise to reimburse the physician. It shall also constitute a ''prior authorization'' for particular treatments.

However, a plan that fails to issue a timely denial of authorization may nonetheless contest the necessity of medical treatment that has been rendered if the plan shows by clear and convincing evidence (A) that its failure to issue a denial of authorization was for good cause~~ or through excusable neglect~~, and (B) that the medical treatment that was rendered was plainly unnecessary.

(f) A failure of the primary treating physician to make a response within 10 days does not preclude the filing of a new request for authorization.

(g) (1) A provider may at any time make a telephonic request of the plan for authorization to proceed with a medical treatment.

(2) A plan that grants a telephonic request for authorization shall, on the request of the provider, forthwith provide the provider with a unique authorization number or within two days provide a written authorization by mail, fax, e-mail, or other method satisfactory to the provider.

(h) If the commissioner finds that a plan has implemented or maintained a utilization review system that does not comply with this section, the commissioner shall notify the plan in writing of that finding and provide the plan with a reasonable period of time, not to exceed 90 days, to correct the noted deficiency. If the commissioner finds that revised system still does not comply with this section, he or she may impose appropriate sanctions pursuant to Section 1386.

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

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